Effective February 26, 2018
Policy Replaced by LCD L33417

BlueCross BlueShield of Alabama

Name of Blue Advantage Policy:
Allergy Testing

Policy #: 071
Category: Laboratory/Medical
Latest Review Date: February 2017
Policy Grade: D

Background:

Blue Advantage *medical policy does not conflict with Local Coverage Determinations (LCDs), Local Medical Review Policies (LMRPs) or National Coverage Determinations (NCDs) or with coverage provisions in Medicare manuals, instructions or operational policy letters. In order to be covered by Blue Advantage the service shall be reasonable and necessary under Title XVIII of the Social Security Act, Section 1862(a)(1)(A). The service is considered reasonable and necessary if it is determined that the service is:*

1. *Safe and effective;*
2. *Not experimental or investigational*;*
3. *Appropriate, including duration and frequency that is considered appropriate for the service, in terms of whether it is:*
   - *Furnished in accordance with accepted standards of medical practice for the diagnosis or treatment of the patient's condition or to improve the function of a malformed body member;*
   - *Furnished in a setting appropriate to the patient's medical needs and condition;*
   - *Ordered and furnished by qualified personnel;*
   - *One that meets, but does not exceed, the patient's medical need; and*
   - *At least as beneficial as an existing and available medically appropriate alternative.*

Routine costs of qualifying clinical trial services with dates of service on or after September 19, 2000 which meet the requirements of the Clinical Trials NCD are considered reasonable and necessary by Medicare. Providers should bill* ***Original Medicare* *for covered services that are related to* ***clinical trials*** *that meet Medicare requirements (Refer to Medicare National Coverage Determinations Manual, Chapter 1, Section 310 and Medicare Claims Processing Manual Chapter 32, Sections 69.0-69.11).*

Description of Procedure or Service:

Allergic or hypersensitivity disorders may be manifested by generalized systemic reactions as well as localized reactions in any organ system of the body. The reactions may be acute, subacute, or chronic, immediate or delayed, and may be caused by numerous offending agents, e.g., pollen, molds, dust, mites, animal dander, stinging insect, venoms, foods and drugs. These substances, when recognized by the cells and antibodies that cause an allergic response, also called allergens. It is essential to the care of allergic patients to determine which allergens may be inciting their disease because this information is used to direct allergy prevention and treatment.

The optimum management of the allergic patient should include a careful history and physical examination and may include confirming the cause of allergic reaction by information from various testing methods. Once the offending allergen is identified treatment is provided by avoidance, medication and/or immunotherapy.

There are a variety of tests to identify the allergens that may be responsible for an individual's allergic disease. These tests include in-vivo skin tests, such as prick and intradermal skin tests, and in-vitro tests, such as radioallergosorbent tests (RAST).

1. Direct Skin Test
   - Percutaneous (scratch, prick, or puncture) tests are performed for inhalant allergies and for suspected food hypersensitivity. This is covered only in patients with documented symptoms following ingestion of certain foods and avoidance of those foods has not proven to alleviate symptoms. Any additional testing would require results of initial screening and patient's history. (CPT **95004, 95010)**
   - Intracutaneous (intradermal) tests are performed commonly when a significant allergic history is obtained and results of the percutaneous tests are negative or equivocal. (CPT **95015, 95024, 95028**)

2. Patch Testing (Application Testing) is also known as delayed hypersensitivity testing and identifies allergens causing contact dermatitis. The suspected allergens are applied to the patient's back under dressings and allowed to remain in contact with the skin for 48 to 72 hours. The area is then examined for evidence of delayed hypersensitivity reactions. (CPT **95044**)

3. Photo Patch Testing reflects contact photosensitization. A patch of skin is applied with the suspected sensitizer for 48 hours. If no reaction occurs, the area is exposed to a dose of ultraviolet light sufficient to produce inflammatory redness of the skin. If the test is positive, a more severe reaction develops at the patch site than on the surrounding skin. (CPT **95052**)

4. Inhalation Bronchial Testing (not including necessary pulmonary function tests), histamine or methacholine is used to perform this test when it is necessary to determine if the patient has hyper-responsive airways. Volatile chemicals are used to perform the test when the allergy is encountered in an occupational setting. If dust,

ragweed or other common allergens are the suspected cause of the problem, this test is not medically appropriate since skin tests can be used in these situations. (CPT **95070**) Inhalation bronchial testing (not including necessary pulmonary function tests); with antigens or gases. (CPT **95071**)

5. Ingestion challenge test (sequential and incremental ingestion of test items, e.g., food, drug or other substance) also known as the Double Blind Food Test. The physician has the patient ingest specific substances, such as food or drugs, to determine which sensitivity is suspected. Both the patient and the physician are blinded. The reaction is documented. (CPT **95076, 95079**)

6. Gammaglobulin, IgE is a testing modality not indicated in most allergic patients, but may be indicated for those patients suspected of having allergic bronchopulmonary aspergillosis, immune deficiency disease characterized by increased IgE levels (e.g., Wiskott-Aldrich syndrome, hyper-IgE staphylococcal abscess syndrome), IgE myeloma or pemphigoid. (CPT **82785**)

7. Allergen specific IgE; quantitative or semiquantitative, each allergen (CPT **86003**). Allergen specific IgE; qualitative, multi-allergen screen (dipstick, paddle or disk) (CPT **86005**). These tests detect antigen-specific IgE antibodies in the patient's serum. They are medically appropriate only when testing for allergens (e.g., inhalant, food, insect, drug): when direct skin testing is impossible due to extensive dermatitis or marked dermatographism; for patients unable to discontinue use of interfering medications (e.g., antidepressants, beta blocking agents); for those who have had a near fatal reaction to an allergen; or in children less than four years of age. Patient must be symptomatic. Medical necessity is not established for in-vitro testing if there are no allergy symptoms. In-vitro testing is the sole testing modality used. When in-vitro testing is performed, additional skin testing is considered not medically necessary. These tests include Radioallergosorbent Test (RAST), Multiple Radioallergosorbent Tests (MAST), Fluorescent Allergosorbent Test (FAST), and Enzyme-linked Immunosorbent Assay (ELISA).

8. Serial endpoint testing (SET) (CPT **95027**) is intradermal testing of varying dilutions of a single antigen. It is the weakest dilution that produces a positive skin reaction and initiates progressive increase in the diameter of the wheals with each stronger dilution.

9. Ophthalmic mucous membrane test (CPT **95060**), also known as conjunctival challenge test, is done by placing an allergenic extract into the conjunctival sac of the eye followed by observation for redness, itchiness, tearing of the eye, and other similar symptoms.

10. Direct nasal mucous membrane test (CPT **95065**), also known as nasal challenge test, provides precise measurements of changes in nasal airway resistance and is seldom used because of the instrumentation required.

11. Provocative testing (CPT **95078**) (e.g., Rinkel test) is performed by injecting (intradermal or subcutaneous) sublingual dilute extracts of the suspected food or inhalant allergen and observing the response or reaction. A symptomatic response indicates an allergy to that food or inhalant, and the reaction can be neutralized by application of a similar extract of a lesser dilution.

12. Cytotoxicity, Leukocytotoxic test (Bryan's test, Metabolic Intolerance Test or sensitivity testing) is a test in which leukocytes from the serum of an allergic individual are observed for histamine release in the presence of an antigen. This test is rarely done except in a research setting.

13. Leukocyte Histamine Release Test (LHRT) is a test which measures the amount of histamine released from the white blood cells in response to exposure to an antigen.

14. Rebuck Skin Window Test is a test of the inflammatory process: Skin is abraded and a cover applied to the abraded area. The cover is replaced at specified intervals and examined for the presence of immune response cells.

15. Passive Transfer of P-X (Prausnitz-Kustner Test) is performed by injecting a serum intradermally from an allergic patient into a non-allergic patient and later challenging the injection site with antigens.

Policy:

Effective for dates of service on or after February 26, 2018 refer to LCD L33417

Effective for dates of service on and after May 11, 2015 and prior to February 26, 2018:
Blue Advantage will treat **allergy testing** as a **covered benefit** when clinically significant allergic symptoms exist; conservative therapy has failed, or has not been tolerated by the patient. The antigens should generate an IgE mediated response and exist in the patient's environment with a reasonable probability of exposure.

Blue Advantage will treat the following **allergy testing modalities** as a **covered benefit when the above medical criteria are met:**

- Direct skin testing-includes percutaneous and intracutaneous
- Specific IgE in Vitro Tests- (RAST, MAST, FAST, & ELISA)
- Total Serum IgE concentration
- Bronchial Challenge Test (only for suspected allergic bronchopulmonary aspergillosis, immune deficiency disease characterized by elevated IgE levels, IgE myeloma, or pemphigoid)
- Double Blind Food Challenge Test
- Serial endpoint testing
- Patch Test

- Photo Patch Test

For the above allergy testing modalities **excluding Patch/Photo Patch** testing, a combination or a total of 65 tests per every three years (based on dates of service) will be considered as medically necessary. Retesting with same antigen should not be necessary within a three-year period unless a patient transfers to another practice, or when a patient is having a poor response to immunotherapy. Documentation would include that the patient continues to have symptoms that interfere with activities of daily living despite optimal immunotherapy. Claims for retesting or additional testing are non-covered unless supporting documentation clearly documents the medical necessity in the individual case. Testing done on a separate day for different antigens is acceptable as long as the number of tests does not exceed the screening limits.

Blue Advantage will consider **Patch/Photo Patch a**llergy testing separate from the above allergy testing modality limits. A limited series of patch tests may be an appropriate initial step. Standard panels of allergens for patch testing are available from various commercial sources; the most commonly used being the T.R.U.E. TEST® by Allerderm. Each T.R.U.E. TEST® patch test unit includes 35 common allergens and a negative control. In addition to the standard series of 36 patch tests, fourteen (14) additional allergens targeted at the patient's most likely exposures may be performed initially. A combination or a total of 50 Patch/Photo Patch test per every three years (based on dates of service) will be considered as medically necessary.

Blue Advantage will consider **more comprehensive patch testing (greater than 50 patch tests)** as a **covered benefit** when **BOTH** a.) and b.) below are met:

a. The patient has persistent allergic contact dermatitis (ACD) after being previously evaluated and treated (including 6 weeks of avoidance of any allergens that were positive on initial patch testing, and use of topical steroid products if appropriate)

OR

The patient has **ANY** of the following:

- At least 8 weeks of dermatitis without resolution with treatment
- Has a dermatitis that may be implanted device-related
- Is undergoing pre-testing for medical or dental device placement
- Requires extensive patch testing to determine if persistent dermatitis is allergic contact dermatitis
- Has seen at least one other physician who has requested specialty patch testing

AND

b. The dermatitis interferes with the patient’s normal activities of daily living, such as occupational or work activities (use of hands), sleep patterns (due to itching), bathing or social interactions.

Greater than 50 patch tests within a three year period may be reviewed by individual consideration. Documentation of medical necessity for over 50 tests will be necessary.

Food allergy testing is covered only in patients with documented symptoms following ingestion of certain foods, and avoidance of those foods has not proven to alleviate the symptoms. An initial screening of no more than 20 foods is covered with documented medical necessity.

Blue Advantage will treat **allergy testing** performed by the following methods as a **non-covered benefit** and as **investigational**:

- Ophthalmic mucous membrane test
- Direct nasal mucous membrane test
- Provocative testing (e.g. Rinkel test)
- Cytotoxicity, Leukocytotoxic test (Bryan's test)
- Mediator Release Test
- Sage Allergy Testing
- Leukocyte Histamine Release Test (LHRT)
- Rebuck Skin Window Test
- Passive Transfer of P-X (Prausnitz-Kustner Test)

Effective for dates of service on or after July 1, 2005 and prior to May 11, 2015:
Blue Advantage will treat **allergy testing** as a **covered** benefit when clinically significant allergic symptoms exist; conservative therapy has failed, or has not been tolerated by the patient. The antigens should generate an IgE mediated response and exist in the patient's environment with a reasonable probability of exposure:

- Direct skin testing-includes percutaneous and intracutaneous
- Patch Test
- Photo Patch Test
- Specific IgE in Vitro Tests- (RAST, MAST, FAST, & ELISA)
- Total Serum IgE concentration
- Bronchial Challenge Test (only for suspected allergic bronchopulmonary aspergillosis, immune deficiency disease characterized by elevated IgE levels, IgE myeloma, or pemphigoid)
- Serial endpoint testing

A combination or a total of 65 tests per every three years (based on dates of service) will be considered as medically necessary. Retesting with same antigen should not be necessary within a three-year period unless a patient transfers to another practice, or when a patient is having a poor response to immunotherapy. Documentation would include that the patient continues to have symptoms that interfere with activities of daily living despite optimal immunotherapy. Claims for retesting or additional testing are non-covered unless supporting documentation clearly documents the medical necessity in the individual case. Testing done on a separate day for different antigens is acceptable as long as the number of tests does not exceed the screening limits.

Blue Advantage will treat **food allergy testing** as a **non-covered** benefit.

Blue Advantage will treat **allergy testing** as a **non-covered** benefit and as **investigational** when performed by the following methods:

- Ophthalmic mucous membrane test
- Direct nasal mucous membrane test
- Provocative testing (e.g. Rinkel test)
- Cytotoxicity, Leukocytotoxic test (Bryan's test)
- Mediator Release Test
- **RUSH Immunotherapy will no longer be investigational**
- Sage Allergy Testing

Blue Advantage does not approve or deny procedures, services, testing, or equipment for our members. Our decisions concern coverage only. The decision of whether or not to have a certain test, treatment or procedure is one made between the physician and his/her patient. Blue Advantage administers benefits based on the members' contract and medical policies. Physicians should always exercise their best medical judgment in providing the care they feel is most appropriate for their patients. Needed care should not be delayed or refused because of a coverage determination.

Key Points:

The American Academy of Allergy, Asthma and Immunology (AAAAI) in its allergy report cites that each year more than 50 million Americans suffer from allergic disease. Rhinitis, sinusitis, dermatitis, asthma, food allergy, and other allergic disorders negatively impact quality of life and escalate healthcare costs. Allergies are the sixth leading cause of chronic disease in the United States and are costing the healthcare system over $18 billion annually.

Approximately 16.7 million office visits to health care providers each year are attributed to allergic rhinitis. It has been estimated that 8 to 10% of children have asthma and 15 to 25 percent have allergic rhinitis. In addition, large numbers of children who suffer from allergic rhinitis have coexisting otitis media and sinusitis.

Atopic dermatitis is one of the most common skin diseases, particularly in infants and children and appears to be on the increase. Atopic individuals (those with allergies) are at an increased risk of developing latex allergy. Experts estimate that food allergy occurs in 8% of children six years of age or under, and in 1 to 2% of adults. Peanut or tree nut allergies affect approximately three million Americans and cause the most severe food-induced allergic reactions. Allergic drug reactions account for 5 to10% of all adverse drug reactions, with skin reaction being the most common form. Allergy to venom of stinging insects is relatively common, with prevalence of systemic reactions in American adults of 3.3 percent.

Allergy Testing

The purpose of allergy testing is to identify the allergens that contribute to the allergic disease process. By identifying the allergen, the patient can avoid exposures, and the disease can be managed appropriately. Allergy testing can be performed for a variety of aeroallergens (inhalant

allergens), foods, latex, venom and some medications. The Annals of Allergy, Asthma, & Immunology, March 2008 (the most updated practice parameter available) summary statement 43, "The number of skin tests and the allergens selected for skin testing should be determined based on the patient's age, history, environment and living conditions (e.g., region of the country), occupation, and activities. Routine use of large numbers of skin tests or routine annual tests without a definite clinical indication are clearly not justified."

Skin testing is a major method for identifying allergen-specific immunoglobulin E (IgE). In-vivo testing techniques are divided into two general categories: percutaneous and intradermal tests. There is no age limit for performing percutaneous; however, children younger than six months of age are rarely tested. Intradermal tests are used commonly when a significant history is obtained and results of the percutaneous tests are negative or equivocal. In-vitro testing is indicated for patients who have severe cutaneous disease, cannot discontinue medications that interfere with skin testing, or have experienced severe anaphylaxis. These tests were developed to measure serum levels of antigen-specific IgE. Radioallergosorbent test (RAST) and enzyme-linked immunosorbent assay (ELISA) are commonly used.

Practice Parameters for Allergy Diagnostic Testing from the *Annals of Allergy, Asthma & Immunology* have reported on the number of skin tests: "The evaluation of inhalant allergy may require up to 70 prick-puncture tests followed by up to 40 intracutaneous tests, which are ordinarily performed when the prick-puncture tests are negative. Under special circumstances and in certain geographic areas, a greater number of tests may be appropriate. However, in many parts of the country and probably in most cases, fewer tests are required." Most individuals who do require testing for allergies have a single round of skin testing. Li, a professor of medicine at the Mayo Clinic, states that allergy to airborne substances is typically evaluated using a panel of percutaneous skin tests for about 40 allergens.

Food Hypersensitivity Testing

Regarding the number of tests performed for suspected food hypersensitivity, numbers can vary from less than 20 to as many as 80. In evaluating patients for food allergies, The Allergy Report from the American Academy of Allergy, Asthma and Immunology states that the patient's history is critical when testing for food allergies. Nearly all food can be allergenic. Skin testing is useful and a negative test strongly indicates against that food being responsible for the reaction. A positive test usually will require correlation with a positive history or food challenge.

The America Academy of Allergy, Asthma and Immunology (AAAAI) and the American College of Allergy, Asthma and Immunology (ACAAI) have jointly established the Allergy Diagnostic Testing: An Updated Practice Parameter (2008). Regarding assessment of food allergy, the summary statement 181 says the primary tools available to evaluate patients' adverse reactions to foods include history (including diet records), physical examination, prick/puncture skin tests, serum tests for food specific IgE antibodies, trial elimination diets, and oral food challenges. With regard to evaluations for IgE antibody-associated food allergies, tests for food specific IgE antibody include percutaneous skin tests (prick/puncture) and serum assays. In general, these tests are highly sensitive, about 85%, but only modestly specific (approximately 40% to 80%) and therefore are well suited for use when suspicion of a particular food is high.

They are not effective for indiscriminate screening (e.g., using panels of test without consideration of likely causes) and therefore generally should not be used for that purpose.

AAAAI's summary statement 105 addresses the clinical efficacy of patch testing in food allergies, "The role of the atopy patch in determining clinical allergy to food is indeterminate."

In-Vitro Testing

In vitro particle size measurement for screening hypersensitivity reactions involves the measurement of the aggregate release of inflammatory mediators from an individual's immunocytes after exposure to various food extract and chemicals. In the Mediator Release Test® or MRT®, the degree of reactivity is determined by the degree of mediator release from the cells. A response, change in cellular and plasma volume, is thought to indicate a hypersensitivity reaction and results are used as a basis for modifying an individual's diet. MRT® is one component of the Lifestyle Eating and Performance (LEAP®) Program of oligoantigenic dieting. This test has been promoted in patients with but not limited to: chronic fatigue syndrome, irritable bowel syndrome, migraine headaches, rheumatologic conditions, and dermatologic conditions. There are no studies of MRT® reported in peer-reviewed published medical literature that demonstrates improvements in clinical outcomes by incorporating the test and associated dietary modifications in to the clinical management of patients. This testing does not meet the TEC criteria for coverage and is considered investigational.

Further information is reported on *in vitro* testing for the diagnosis of IgE-mediated disorders by Hamilton and Adkinson. Hamilton and Adkinson state that current analytic methods for IgE antibodies provide more quantitative and reproducible measurements of IgE than ever before, although still with less sensitivity than traditional skin testing. The current challenge is to translate the quantitative IgE antibody results into a more accurate diagnosis of allergic disease. The traditional wheal and flare skin test remains the gold standard for IgE antibody detection largely because of its unexcelled sensitivity. Advancing technologies are increasing the attractiveness and cost-effectiveness if multiple and simultaneous *in vitro* assessments of IgE antibodies but also the potential for misuse.

Patch Testing

Patch testing is utilized to identify substances which may be causing allergic skin reactions which are not identified by skin prick testing. Positive patch tests will produce a local allergic reaction on the skin where patches have been applied with a diluted concentration of specific chemical allergens.

The AAAAI summary statement 90 states, "The chief limitation to traditional patch testing for the diagnosis of ACD is the lack of a suitable gold standard by which it can be evaluated in terms of diagnostic accuracy predictors and likelihood ratios." This document further states "The diagnostic value of patch tests hinges on reproducibility. Although an earlier study found 40% of patch tests to be nonreproducible, recent studies have shown excellent reproducibility and reliability for a test panel of 30 allergens from different commercial sources, with 97.1 concordant negative and 95% concordant positive results. This degree of reproducibility also applies to the TRUE test."

The 2008 practice parameter summary statement 80 on patch testing: "The most common patch test techniques are the individual Finn Chamber and the TRUE Test; an FDA approved screening method for screening contactant allergens." "Fewer than 40 allergens produce most cases of ACD. The allergens formulated in the TRUE test panel can be estimated to identify approximately 25-30% of clinically relevant causes of ACD."

Additionally, AAAAI's summary statement 88 addresses patient selection, "Patch tests are most effective when the patients are selected on the basis of a clear-cut clinical suspicion of contact allergy and they are tested with chemicals relevant to the problem; these conditions satisfy the prerequisites of high pretest probability."

Other Testing

Procedures for which there is no evidence of diagnostic validity include cytoxic tests, provocation-neutralization, electrodermal testing, applied kinesiology, iridology, hair analysis, or food specific IgG, IgG4, and IgG/IgG4 antibody tests. (Summary statement 154)

Guidelines and Position Statements

Position Statement 2 from the American Academy of Allergy, Asthma and Immunology states that there are certain techniques for allergy testing that is controversial techniques. These are:

1) Skin end point titration
2) Provocative testing with intracutaneously injected antigen
3) Desensitization by sublingual application of antigen; this also includes cytotoxic testing.

Position Statement 6 from the American Academy of Allergy, Asthma and Immunology, addresses allergen standardization; Radioallergosorbent and IgE Tests in practice are addressed as: "For routine diagnosis of specific allergens responsible for IgE medicated disease, skin tests with appropriate allergenic extracts are superior to radioallergosorbent tests because they are more sensitive, quicker, less expensive, and better standardized. Radioallergosorbent tests should be reserved for situations where skin testing is unsatisfactory." Radioallergosorbent testing should not be used for monitoring of immunotherapy. Total serum IgE tests are useful for identifying an atopic condition and in diagnosis of bronchopulmonary aspergillosis and in assessing the response to treatment. Cytotoxic testing has also been determined as ineffective for diagnosing food or inhalant allergies.

American Academy of Allergy, Asthma and Immunology and American College of Allergy, Asthma and Immunology: a 2008 guideline of allergy diagnostic testing includes the following recommendations on intracutaneous:

"When compared with specific nasal, skin end point titration (SET) is equivalent to prick/puncture skin tests".

"Intracutaneous tests should be performed with small volumes (approximately 0.02 to 0.05 mL) of allergens injected intracutaneously with a disposable 0.5-1.0mL syringe."

"As a general rule, the starting dose of an intracutaneous allergen test ranges from 100- to 1,000-fold more dilute than the allergen concentration used for prick/puncture tests."

Key Words:

Gammaglobulin, IgE, allergen, intradermal, percutaneous, intracutaneous, provocative testing, bronchial challenge testing, direct skin test, patch test, application test, photo patch test, ingestion challenge test, serial endpoint testing, SET, ophthalmic mucous membrane test, direct nasal mucous membrane test, Rinkel test, cytotoxic testing, leukocytotoxic test, Bryan's test, Metabolic intolerance test, Radioallergosorbent test, RAST, Multiple radioallergosorbent test, MAST, Fluorescent allergosorbent test, FAST, Enzyme-linked immunosorbent assay, ELISA, in-vivo, in-vitro, RUSH immunotherapy, mediator release test, MRT, LEAP, Sage allergy testing, T.R.U.E® Test

Approved by Governing Bodies:

Not applicable

Benefit Application:

Coverage is subject to member's specific benefits. Group specific policy will supersede this policy when applicable.

Current Coding:

CPT Codes:

82785	Gammaglobulin (immunoglobulin); IgE
83516	Immunoassay for analyte other than infectious agent antibody or infectious agent antigen, qualitative or semiquantitative; multiple step method
86001	Allergen specific IgG quantitative or semiquantitative, each allergen
86003	Allergen specific IgE; quantitative or semiquantitative, crude allergen extract, each ~~allergen~~
86005	Allergen specific IgE; qualitative, multi allergen screen (disk, sponge, card)
86008	Allergen specific IgE; quantitative or semiquantitative, recombinant or purified component, each **(Effective 01/01/2018)**
86486	Skin test; unlisted antigen, each
95004	Percutaneous tests (scratch, puncture, prick) with allergenic extracts, immediate type reaction, including test interpretation and report, specify number of tests
95017	Allergy testing, any combination of percutaneous (scratch, puncture, prick) and intracutaneous (intradermal), sequential and incremental, with venoms, immediate type reaction, including test interpretation and report, specify number of tests **(Effective 01/01/2013)**

95018	Allergy testing, any combination of percutaneous (scratch, puncture, prick) and intracutaneous (intradermal), sequential and incremental, with drugs or biologicals, immediate type reaction, including test interpretation and report, specify number of tests **(Effective 01/01/2013)**
95024	Intracutaneous (intradermal) tests with allergenic extracts, immediate type reaction, including test interpretation and report, specify number of tests
95027	Intracutaneous (intradermal) tests, sequential and incremental, with allergenic extracts for airborne allergens, immediate type reaction, including test interpretation and report, specify number of tests
95028	Intracutaneous (intradermal tests with allergenic extracts, delayed type reaction, including reading, specify number of tests
95044	Patch or application test(s) (specify number of tests)
95052	Photo patch test(s) (specify number of tests)
95056	Photo tests
95060	Ophthalmic mucous membrane tests
95065	Direct nasal mucous membrane test
95070	Inhalation bronchial challenge testing (not including necessary pulmonary function tests); with histamine, methacholine, or similar compounds
95071	Inhalation bronchial challenge testing (not including necessary pulmonary function tests); with antigens or gases, specify
95076	Ingestion challenge test (sequential and incremental ingestion of test items, e.g., food, drug or other substance); initial 120 minutes of testing
95079	Ingestion challenge test (sequential and incremental ingestion of test items, e.g., food, drug or other substance); each additional 60 minutes of testing (List separately in addition to code for primary procedure
95199	Unlisted Allergy/Clinical Immunologic Service or Procedure

Previous Codes:

CPT Codes:

95010	Percutaneous tests (scratch, puncture, prick) sequential and incremental, with drugs, biologicals or venoms, immediate type reaction, including test interpretation and report by a physician, specify number of tests **(Deleted 01/01/2013)**
95015	Intracutaneous (intradermal) tests, sequential and incremental, with drugs, biologicals, or venoms, immediate type reaction, including test interpretation and report by a physician, specify number of tests **(Deleted 01/01/2013)**
95075	Ingestion challenge test (sequential and incremental ingestion of test items, e.g., food, drug, or other substance such as metabisulfite) **(Deleted 01/01/2013)**

95078 Provocative testing (e.g., Rinkel test) **(Deleted 01/01/2007)**

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Medical Policy Group, June 2010
Medical Policy Group, January 2011
Medical Policy Group, March 2011
Medical Policy Group, June 2012
Medical Policy Group, November 2012
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